NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions.
Thank You

Name _____ Date_____

Address _____ City/State/Zip_____

Birthdate _____Age _____ Marital Status: M/W/D/S Social Security #_____

Home _____ Cell _____Work _____ Email _____

Employer _____ Phone Number _____

Employer's Address _____City/State/Zip_____

Occupation _____

Favorite Hobbies or Interests _____

Spouse's Name_____ Birthdate_____ Employer_____

Children's Names & Ages _____

Name of previous Doctor of Chiropractic _____ Phone _____

Address_____ Approx date of last visit_____

Chiropractic techniques you have had success with _____

_____

General Practitioner_____ Phone Number _____

Address_____

Do you have health insurance? Please name all companies in order of priority:
Primary _____ Secondary _____

Method of Payment for first visit _____ Cash _____Check

Health reasons for consulting our office:_____
_____

Have you had same or similar problem(s) before _____ Yes _____ No How long? _____
Please explain_____

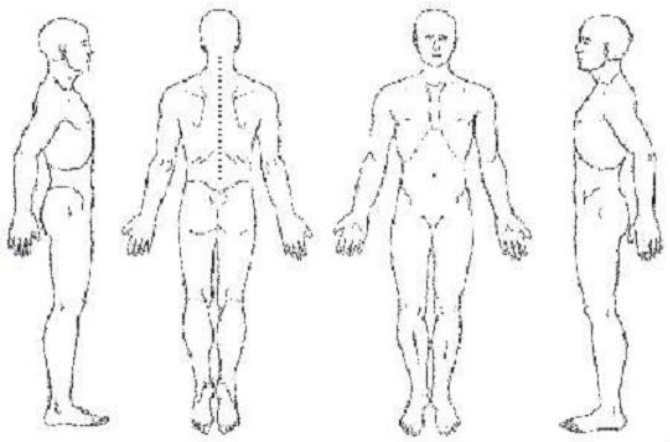
Father/Mother/Brother/Sister/Children,
with similar problems? _____
_____

Please mark areas of health concern on diagram

Other doctors who have treated this problem:
_____

Surgery you have had: _____
_____

Medication(s) you currently take_____
_____
_____
_____



Is there any chance you are pregnant? _____

Is this the result of an auto or work injury? _____ If so, when? _____
If this is a work injury, is there a panel chiropractor that your company's Workmen's Compensation Insurance requires you to see in the first 90 days? If so, please list their name.
_____

What have you heard about chiropractic care?_____
Do you know what a subluxation is? If yes, please describe_____
_____
What daily rituals for spinal health do you presently practice?_____

Have you ever been diagnosed with cancer? _____ If so, what type?_____

Who may we thank for referring you? _____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient/Parent/Guardian Signature _____ Date _____